



Wraparound Milwaukee – REACH Program  
**DISENROLLMENT DOCUMENTATION**

Name of Child \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_ Social Security Number \_\_\_\_\_

Requested Date of Disenrollment \_\_\_\_\_

Date of Disenrollment Plan of Care Meeting \_\_\_\_\_ DOB \_\_\_\_\_

Signatures of Team Members Present at the Disenrollment Team Meeting:

Team Member Signatures

_____	_____	_____
Youth	Team Member	Role
_____	_____	_____
Parent/Guardian	Team Member	Role
_____	_____	_____
Care Coordinator	Team Member	Role
_____	_____	_____
Supervisor	Team Member	Role

**Note: If unable to obtain parent/guardian and/or youth signatures at disenrollment plan of care, please indicate reason and attach progress notes from previous month and certified mail receipts.**

Reason for Disenrollment:

- ☐ Youth/family have made substantial progress and needs have been met.  
☐ Youth/family have made progress, some needs remain. Continuing services have been arranged.  
☐ Youth's Medicaid eligibility changes.  
    *Level of Progress Made: \_\_\_ Substantial \_\_\_ Some \_\_\_ Needs Not Met*  
☐ Youth/family moved out of county.  
    *Level of Progress Made: \_\_\_ Substantial \_\_\_ Some \_\_\_ Needs Not Met*  
☐ Youth/family no longer desire Wraparound services.  
    *Level of Progress Made: \_\_\_ Substantial \_\_\_ Some \_\_\_ Needs Not Met*  
☐ Family/Youth missing more than 30 days  
☐ Other (explain): \_\_\_\_\_  
    *Level of Progress Made: \_\_\_ Substantial \_\_\_ Some \_\_\_ Needs Not Met*

Disenrollment Reviewed and Approved by:

\_\_\_\_\_  
\_\_\_\_\_  
Date  
Date

Disenrollment is: ☐ Approved ☐ Denied  
(For EDS Use Only)  
Effective Date of Disenrollment \_\_\_\_\_  
Reason for Denial \_\_\_\_\_